Hospice, Long Term Care

Covered services

Providers should bill using their provider type 65 to receive room and board reimbursement for those hospice recipients residing in a nursing facility. Medicaid provides coverage for room and board in a nursing facility pursuant to the Nevada Medicaid Services Manual Chapters 500 and 3200. Services unrelated to the terminal illness billed by non-hospice providers may be covered subject to the specific program's limitations.

Non-covered services

No reimbursement is provided for curative services.

Prior authorization requirements

Prior authorization is required for all services unrelated to hospice benefits.

Special billing instructions

All hospice claims are to be billed on a monthly basis. All claims should be submitted to Hewlett Packard Enterprise during the first week of the month following the month of service.

The National Provider Identifier (NPI) of the nursing facility from which the recipient was transferred, if applicable, must be provided in Field 77 of the paper UB-04 claim form and in Loop 2310E Segment REF of the 837I electronic transaction.

Report the Service Location for the nursing home on the 837I electronic transaction as follows:

2310E NM101 = 77 Entity Identifier Code

2310E NM102 = 2 Non-Person Entity

2310E NM103 = Provider Name

2310E NM108 = XX NPI Qualifier

2310E NM109 = NPI

Notes

All hospice-enrolled recipients must have a Pre-Admission Screening and Resident Review (PASRR) and a Level of Care (LOC) screening prior to admission to a nursing facility.

All required documentation must be received in order for the Division of Health Care Financing and Policy (DHCFP) to issue a Billing Authorization Letter to the provider. See the Nevada Medicaid Services Manual, Chapter 3200 for documentation requirements.

A hospice physician or nurse practitioner (NP) must have a face-to-face encounter with the recipient to determine continued eligibility prior to the 180th day of recertification, and prior to each subsequent recertification. The face-to-face encounter must occur no more than 30 calendar days prior to the third benefit period recertification and no more than 30 calendar days prior to every subsequent recertification. The face-to-face encounters are used to gather clinical findings to determine continued eligibility for hospice services.